

Reality Makes Our Decisions: Ethical Challenges in Humanitarian Health in Situations of Extreme Violence

REPORT AND RECOMMENDATIONS

A COLLABORATION AMONG

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CENTER FOR PUBLIC HEALTH AND HUMAN RIGHTS



CENTER FOR HUMANITARIAN HEALTH



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EXECUTIVE SUMMARY

This project explored the ethical challenges humanitarian health organizations face in situations of extreme violence against civilians, particularly when healthcare facilities and personnel become targets in the conflict. Its objective was to provide processes and mechanisms as well as practical tools to guide humanitarian health organizations through complex ethical challenges facing them in these settings.

The project originated as a result of the challenges international and local non-governmental organizations (NGOs) and front-line health workers face as a result of violence inflicted on hospitals and health workers in Syria. At times, individuals in these settings must forgo compliance with core ethical commitments, choose to comply with one ethical obligation at the expense of another, or to take an action where no obviously right action exists.

For example, when a hospital is attacked and cannot continue operations, is it better to rebuild at the same location or move to a safer one farther away—even when doing so may hinder access to health care for some individuals and communities? How much deference should be shown to local communities that do not want a hospital nearby because they may be at risk of further shelling or bombing from targeted campaigns? In these circumstances, moreover, front-line health workers may experience severe psychological impacts as well as moral distress, which occurs when someone knows what the ethically right action is, but because of constraints imposed it cannot be taken.

Although the research focused on Syria, we hope that the recommendations that flow from the

project may be useful in other violent contexts where humanitarian organizations work.

ETHICAL FOUNDATIONS OF THE PROJECT OVERVIEW

This project was guided by ethical and humanitarian principles. Ethics, at its core, involves the systematic study of the fundamental values and norms that help individuals, organizations, and societies determine what ought to be done, including what ought to be done when values and norms may be in tension, perhaps irreconcilably so. This project employed a principlist approach that is widely accepted in the humanitarian community through such vehicles as the SPHERE Humanitarian Charter.

Ethical principles in health care relevant here include *respect for persons* to advance human dignity and for individuals' autonomous choices; *beneficence*, the promotion of others' well-being; *non-maleficence*, commonly known as “do no harm,” and *justice*, encompassing both the fair distribution of resources and fair processes for decision-making. Humanitarian principles are a second source of values and norms that animate the actions of humanitarian organizations. They include *humanity*, requiring that suffering must be addressed wherever and for whomever it is found; *neutrality*, the duty of humanitarian actors not to take sides in a conflict; *impartiality*, which stipulates that humanitarian actors must not discriminate or give preference to any nationality, race, religious belief, class, political opinion, or similar status; and *independence*, which demands that humanitarian actors retain their autonomy and remain independent of political or military objectives of other actors.

METHODS

We conducted a **systematic literature review** to understand the range of ethical challenges in humanitarian health practice in conflict settings and the approach taken to their resolution, as described in peer-reviewed literature.

We **interviewed** 41 managers working in Turkey and Jordan engaged in supporting organizations operating in Syria and 58 frontline health workers in northwestern and southern Syria to learn about the challenges individuals and organizations faced in providing health care, their perceptions of the ethical dimensions of those challenges, how they sought to address the challenges, and how the violence affected their well-being. We then held **workshops** in Amman (Jordan) and Gaziantep (Turkey) with health program staff to review the findings of the literature review, the interviews and two proposed decision-making tools for addressing ethical challenges in humanitarian health practice.¹ Participants discussed practical recommendations and implementation steps to address the ethical challenges.

KEY FINDINGS

LITERATURE REVIEW

The most frequently reported ethical challenges identified in an in-depth analysis of 66 studies from a group of 2,077 potentially relevant publications related to providing the highest attainable quality of care, properly managing assets, and protecting and caring for health workers. The humanitarian principle most frequently noted as challenging to uphold was neutrality, followed by independence, humanity, and impartiality. We found important areas overlap and reinforcement, as well as tension, between ethical and humanitarian principles in the literature.

MANAGER AND FRONT-LINE WORKER INTERVIEWS

The effects of targeted attacks: Front-line health workers accepted the risks of choosing to remain

in Syria to provide care, often expressing a strong sense of moral duty to their country and fellow citizens. They confronted many difficult decisions, for example whether to close down facilities or pause services after attacks or limit the length of patient stays, which could potentially compromise the health status of patients. Relocating facilities underground or to new communities sometimes created tensions with people in communities who were concerned that the presence of a hospital made them more vulnerable to attack.

Limitations of resources: Staff shortages, lack of qualified staff, and not enough bed capacity, medication, or equipment in facilities created challenges about who should get care and who should provide care under what standard of quality. To some extent, over time, skills training helped address the problem of staff engaged in medical practice beyond their training after a bombardment. Traditional principles of triage were strained. Trauma care sometimes was provided at the expense of primary care.

Access restrictions: Border closings and travel restrictions, as well as Syrian government restrictions, limited the ability to provide supplies and medications in parts of Syria, especially in besieged areas. Some interviewees noted that hospitals near the Turkish border in northwestern Syria were better equipped and more able to attract and retain higher qualified staff than locations subjected to bombing. While this strategy increased access to care for many, it resulted in problems of equity for populations who could not access these facilities.

Constraints on care imposed by other actors:

Without exception, front-line health workers and site managers expressed a commitment to the principle of impartiality in care and to qualifications-based

¹ One of the tools is described in: Clarinval C, Biller-Andorno N. Challenging operations: an ethical framework to assist humanitarian aid workers in their decision-making processes. *PLOS Currents Disasters* 2014, edition 1. The other is described in: Fraser V, Hunt MR, De Laat S, Schwartz L. The development of a Humanitarian Health Ethics Analysis Tool. *Prehosp Disaster Med* 2015; **30**: 412–20. See also, Fraser V, Hunt MR, Schwartz L, De Laat S. Humanitarian Health Ethics Analysis Tool: HHEAT handbook, 2014. <https://humanitarianhealthethics.net>.

hiring. Armed groups, however, sometimes demanded priority in treatment or preferential hiring, employing verbal threats, harassment, and humiliation as means of coercion. Sometimes donors' funding restrictions and accountability standards could limit service provision.

Challenges in making difficult medical and operational decisions. Organizations running or supporting health facilities and personnel from outside Syria provided material and financial support, but some front-line health workers found that support too limited. Remote management staff were often too far removed from operations to be able to advise in real-time. Additionally, they often lacked comprehensive policies to address critical and emergent issues with ethical implications, such as relocating facilities, pausing or re-instating services, transitioning to routine health services, triaging and prioritizing patients, coping with high volumes of trauma cases, managing under-qualified staff, addressing staff turn-over and burn-out, providing psychological supports to staff, involving local communities in decision-making, and advising on negotiations with military or paramilitary groups.

While these gaps gave front-line health workers a certain degree of freedom and independence, it also placed pressure on them at critical times. Front-line health workers also reported that organizations that paid salaries lacked policies on compensating families in the event they were killed in an attack. Women respondents noted that organizational support for addressing gender discrimination was often lacking.

The toll on the mental health of healthcare

workers: Health workers faced significant psychological burdens and distress resulting from working long hours under the strains of these conditions. Many respondents described moral distress in having to make wrenching life-and-death decisions, including determining priority cases based on resources available, while feeling that they were falling short of their commitment to ethics and the principle of humanity

Respondents expressed a sense that the current circumstances left them no choice but to stay in Syria and help but were also aware that their decisions deeply affected their families, yet another cause of psychological distress.

WORKSHOPS

Workshop participants emphasized that the most difficult ethical challenges they have faced are a product of violations of the laws of war that would best be ameliorated or avoided by **securing compliance with the laws**. Participants believed **there was a need for more systematic discussion of ethics in their organizations**, including guidance on how to use these principles to address real-world challenge, e.g., specifying principles at stake, identifying ways to balance harms and benefits of a particular course of action, and finding ways of mitigating harms. **Consensus existed on the creation of structures and processes for addressing ethical challenges, training, and use of decision-making tools, organization-wide training, and engaging communities.**

RECOMMENDATIONS

- 1. Commit time and resources to addressing key ethical issues the organization and the health professionals it supports face.**
- 2. Articulate clear ethical and humanitarian principles as a foundation to address the challenges they face.** These can be based on principles widely accepted in the humanitarian community, as supplemented by the organization's particular values.
- 3. Provide regular training and support in ethics to staff within the organization.** This includes training on core ethics and humanitarian principles, an introduction to ethical decision-making processes within the organization, and tailored instruction in the unique historical and cultural context, and previous experience in that context, at the site(s) where an organization operates.
- 4. Create processes and mechanisms within the organization to support ethical decision-making and recording and disseminating the decisions.** This includes creating easily accessible structures to facilitate, record and disseminate decisions, adopting decisional tools for addressing ethical questions, and engaging with collaborating organizations.
- 5. Provide support for the mental health and psychosocial needs of staff and others supported by the organization.** This includes programs for the psychological well-being of health workers and managers working in violent contexts to help them cope with the extreme danger, stress, and moral distress they may experience. Particular attention should be given, where applicable, to the gender-specific needs of female staff.

While the recommendations are directed at humanitarian health organizations, we emphasize the important responsibility donors have in providing the support organizations need to carry them out.

I. INTRODUCTION TO THE PROJECT

A | OVERVIEW

Humanitarian health organizations face enormous ethical challenges in conducting their operations. For the purposes of this project, we defined ethical challenges broadly to include situations where the best moral course of action could be unclear (e.g., when additional deliberation or analysis is necessary to define the right action), where it might not be possible to fully uphold all the moral values at stake (e.g., when a duty to avoid harm conflicts with the duty to serve all equally), where the moral course of action is clear but circumstances prevent one from taking it, or where there is no right answer but action is needed.

This project, a collaboration involving researchers and staff from the Johns Hopkins Bloomberg School of Public Health, the Johns Hopkins University Berman Institute of Bioethics, the Syrian American Medical Society (SAMS) and the International Rescue Committee, explores the ethical challenges organizations face in situations of extreme violence, particularly when healthcare facilities and personnel become targets in the conflict. It seeks to provide a framework of principles for ethical decision-making in these circumstances as well as to suggest processes and mechanisms to address ethical challenges to organizations and entities that (1) provide or oversee health services within Syria, including international and Syrian non-governmental organizations (NGOs) and local health directorates; and (2) international and Syrian NGOs that provide various forms of support to entities or health workers from outside Syria, usually basing operations in Jordan or Turkey. As similar issues

arise in places such as the Democratic Republic of Congo, Afghanistan, and Yemen, we hope that its recommendations can be helpful for humanitarian work elsewhere.

Ethical challenges result from many factors including scarcity of resources, limitations of access to populations in need, shifting priorities of the organization and its donors, and demands placed by host governments and armed groups. They also arise in complex cultural environments, where the underlying social and political injustices frame people's perceptions and actions. In armed conflicts increased risk to humanitarian organizations and the communities they serve, scarce resources and vast need amplify ethical challenges at all levels, from clinical practice in the field to organizational resource allocation and decision making.

Importantly, the challenging decisions humanitarian organizations experience in situations of extreme violence are often a product of war crimes against health workers and the population they serve. This targeted violence requires sometimes agonizing choices such as outsourcing risk to individual providers and to communities, as well as compromising quality standards that go well beyond the usual challenges faced by humanitarian organizations.

For example, how much personal risk or injury or even death should health workers take on when attempting to provide aid to others? What are these health workers owed in return? After a hospital is attacked, is it better to rebuild at the same location or move to a safer one farther away when doing so may hinder access to the facility for some individuals and communities? How can a humanitarian organization maintain its independence, both real and perceived, when it is also committed to supporting locally-led responses?

Making these decisions is extremely difficult and can lead to moral distress, which occurs when

someone knows what the ethically right action is, but because of constraints imposed, it cannot be taken. There is increasing evidence of the consequences of moral distress in humanitarian practice, including feelings of anger, powerlessness, fear and self-doubt that can undermine staff well-being and effectiveness.²

B | SYRIAN CONTEXT

The war in Syria is characterized by an extraordinarily high level of deliberate violence against health workers and facilities, mostly by the Syrian regime, Russia, and ISIS.³ The prohibitions against attacking or interfering with hospitals, health workers, the wounded and sick that date back to the original Geneva Convention of 1864 are now recognized as war crimes have been breached with impunity. The atrocities and other dimensions of the war have had major implications for health care:

→ Bombing and shelling of hospitals. Since the war began in 2011, there have been more than 550 instances of bombing or shelling of hospitals through 2018, affecting almost 350 facilities,⁴ and 54% of the 891 reported killings of medical personnel were a product of targeted bombing or shelling. Some of the attacks have involved chemical weapons.⁵ Hospitals have also lost large numbers of staff, as health workers have fled as a result of the violence. This has led to a severe shortage of human resources for health, as well

as skills shortages among those who remain. Those who have stayed often suffer psychological trauma.⁶⁻⁷

- Restricted access. Certain cities in Syria were under siege for extended periods of time, and the Syrian government impeded international and Syrian NGOs from accessing those areas.⁸ Additionally, in southern Syria, the border with Jordan has been closed for a long period, preventing face-to-face contact between international humanitarian groups, their staff and local partners inside Syria. In the northwest, international and Syrian NGOs based in Turkey have greater access to staff and partner organizations they support, although there are still limitations to the number of staff who are allowed to cross the border.
- Fragmented management and organization of services. Humanitarian response in Syria is fragmented in multiple ways as a result of the war, e.g., between government-controlled and non-government-controlled areas, between opposition-controlled areas in the northwest and south, between the UN and NGOs, between local and international NGOs. The WHO health clusters based in Gaziantep (Turkey) and Amman (Jordan) have taken steps to better coordinate services in the northwest and south respectively.⁹ In opposition-controlled areas in the northwest, ad hoc health directorates have been formed to govern local health services.

² Smith J. Difficult decision-making, compromise, and moral distress in medical humanitarian response. In: Ahmad A and Smith J, eds, *Humanitarian action and ethics*. London: Zed Books, 2018.

³ Fouad M, Sparrow A, Tarakji A, et al. Health workers and the weaponization of health care in Syria: a preliminary inquiry for *The Lancet-American University of Beirut Commission on Syria*. *Lancet* 2017; **390**: 2516–26.

⁴ Physicians for Human Rights. Findings of attacks on health care in Syria (as of December 2018). <http://syriamap.phr.org/#/en/findings>.

⁵ Ibid.

⁶ Fouad M, Sparrow A, Tarakji A, et al (2).

⁷ Footer, K, Clouse E, Rayes D, Sahloul Z, Rubenstein L. Qualitative accounts from Syrian health professionals regarding violations of the right to health, including the use of chemical weapons, in opposition-held Syria. *BMJ Open* 2018; **8**: e021096. doi:10.1136/bmjopen-2017-021096.

⁸ Fouad M, Sparrow A, Tarakji A, et al (2).

⁹ See, for example: WHO. Turkey Health Cluster coordination compact.

→ Criminalization of health care. Health providers in opposition-controlled areas in the northwest and south are labeled by the government as terrorists or facilitators of terrorism, and are subject to persecution, arrest and imprisonment.¹⁰

Steps to mitigate the impact of the bombing and shelling of hospitals have included moving hospitals closer the border and moving health facilities underground. To enable health services to continue, donors and NGOs provide extensive salary support, supplies, fuel, equipment, medication, training and technical assistance to hospitals and their staffs. Yet these cannot completely ameliorate the severe impacts of bombing and shelling.

Over the course of the war, NGOs have expanded primary care through mobile and fixed clinics in opposition-controlled areas of northwestern and southern Syria to the point where, according to the WHO, in 2018 there were more than a million primary care visits in northwestern Syria alone. Though there are gaps in geographical coverage and these facilities are not immune from attack, these clinics have been less subjected to violence than hospitals

C | ETHICAL AND HUMANITARIAN PRINCIPLES

To the extent that decisions about the right action in a particular circumstance involve determining what is best, what is most appropriate, what should be done, who is responsible, and so on, they involve ethical considerations at every step. So understood, almost every logistical or operational question involves ethics, implicitly or explicitly. Ethics has, at its core, the systematic study of the

fundamental values and norms that help individuals, organizations, and societies determine what ought to be done, including what ought to be done when values and norms may be in tension, perhaps irreconcilably so. Ethical questions rarely have straightforward answers.

From the standpoint of ethics, we adopted a principlist approach, which focuses on commonly shared values as the basis of action-guiding principles. This approach is familiar to those in clinical care and research settings and is widely accepted in the humanitarian community. For example, the SPHERE Humanitarian Charter¹¹ emphasizes core principles including humanity, impartiality, non-discrimination, the right to protection and security, and the right to receive humanitarian assistance.

The ethical principles include respect for persons (i.e., respect for human dignity and for individuals' autonomous choices), beneficence (the promotion of others' well-being), non-maleficence "do no harm", and justice (in both fair distribution of resources and fair processes for decision-making). These four principles, can be adapted to the provision of health care to communities, though how the principles are weighed and applied might differ.¹² For example, in community or public health ethics, the principle of justice may be more emphasized than the principle of autonomy.

From these non-hierarchical ethical principles, concrete ethical obligations can be derived to guide action in specific circumstances. Although universal agreement is lacking on how bioethics principles apply to population health care,¹³ the literature review discussed below shows that reliance on these principles is helpful in identifying obligations of

¹⁰ Fouad M, Sparrow A, Tarakji A, et al (2).

¹¹ SPHERE Project. The humanitarian charter. <https://www.spherestandards.org/wp-content/uploads/2018/07/the-humanitarian-charter.pdf>.

¹² Kass N. Public health ethics: from foundations and frameworks to justice and global public health. *J Law Med Ethics* 2004; **32**: 232-42.

¹³ Lee L. Public health ethics theory: review and path to convergence. *Public Health Reviews* 2012; **34**: 1-26.

humanitarian organizations in situations of conflict, especially those involving extreme violence.

Humanitarian principles are a second source of values and norms that can animate the actions of humanitarian organizations. *Humanity* means that human suffering must be addressed wherever and for whomever it is found. *Neutrality* is the duty that humanitarian actors must not take sides in a conflict. *Impartiality* stipulates that humanitarian actors must not discriminate or give preference to any nationality, race, religious belief, class, or political opinion. Independence demands that humanitarian actors retain their autonomy and remain independent of political or military

objectives of other actors. The humanitarian principles of humanity and impartiality are founded on moral principles that also undergird public health ethics and are reflected in the Geneva Conventions' provisions for protecting and respecting the wounded and sick. On the other hand, the humanitarian principles of neutrality and independence are operational in nature and can be viewed as a means for humanitarian organizations to fulfill the principles of humanity and impartiality.¹⁴ Recently there has been a discussion of a fifth principle, solidarity, which generally refers to an underlying commitment by humanitarians to build trust and cooperation with beneficiaries and communities.¹⁵

¹⁴ Labbe J and Daudin P. Applying the humanitarian principles: reflecting on the experience of the International Committee of the Red Cross. *Int Rev Red Cross* 2016; **97**: 183–210.

¹⁵ See, for example: Slim H, Relief agencies and moral standing in war: Principles of humanity, neutrality, impartiality and solidarity. *Dev Practice* 1997; **7**: 342–52. Also: Scott-Smith T. Humanitarian dilemmas in a mobile world. *Refugee Survey Quarterly* 2016; **35**: 1–21.

II. METHODS

A team of researchers from the Johns Hopkins Bloomberg School of Public Health and the Johns Hopkins Berman Institute of Bioethics, along with the International Rescue Committee (IRC) and the Syrian American Medical Society (SAMS), undertook a project to understand the ethical challenges international and Syrian NGOs, health directorates and local health providers face in providing health care during the Syrian conflict. The project also aimed to give guidance to health providers working in the field and increase their ability to address these challenges.

The project has four components: (1) a systematic literature review of relevant ethics and humanitarian principles and strategies; (2) interviews with key informants from international and Syrian NGOs along with background information about their work; (3) in-depth interviews with individuals providing health care services in northwestern and southern Syria; and (4) workshops with NGOs, front-line health workers and UN staff in Gaziantep, Turkey and Amman, Jordan. The project was approved by the Johns Hopkins Bloomberg School of Public Health Institutional Review Board, the Gaziantep University Clinical Research Ethical Committee, the Jordan University of Science and Technology, and the Aleppo Health Directorate.

A | LITERATURE REVIEW

To better understand the types of challenges experienced in the context of extreme violence, we systematically reviewed peer-reviewed literature about humanitarian work in conflict situations. We developed a broad search strategy for English

language publications available in Medline, EMBASE, and Scopus databases. The search relied upon three key concept blocks: conflict settings, humanitarian or relief organizations, and non-clinical or non-military ethics. To be included, a publication had to (1) include reference, implicitly or explicitly, to ethics and/or humanitarian principle(s), (2) relate to non-military relief work in active conflict or conflict-affected settings, (3) relate to organizational mission and/or delivery of services, and (4) relate to events occurring in the 20th or 21st centuries. Included publications were qualitatively analyzed using emergent thematic analysis approach that mapped reported challenges onto ethical obligations and humanitarian principles. Gray literature, reports by practitioners and scholars not published in peer-reviewed journals, was excluded.

A codebook was developed based on two primary categories, ethical obligations and humanitarian principles. The ethical obligations category drew upon existing literature on ethical issues for humanitarian organizations and in humanitarian interventions generally (not just settings of extreme violence), in pandemics (e.g., influenza and Ebola), in conducting research on sexual violence in emergency situations, and other related areas. The humanitarian principles category drew upon the four widely accepted humanitarian principles (neutrality, impartiality, humanity, and independence). Within these categories, subcategories were created to accommodate specific obligations and principles, as well as specific challenges to fulfilling them.

The codebook was reviewed and revised based on a preliminary review of selected literature, and in that process the emerging humanitarian principle of solidarity was added, which generally refers to an underlying commitment by humanitarians to build trust and cooperation with beneficiaries and communities. The originally selected articles were re-coded by two team members to check for reliability of the coding process, after which they independently coded all the articles.

B | ORGANIZATIONAL MANAGER INTERVIEWS

We conducted 41 key informant interviews with management representatives of 21 international and Syrian NGOs providing health services in Syria, one UN agency and three independent groups based in Turkey and Jordan; 32 of the interviewees were male and 9 were female. Seven of the interview sessions included more than one interviewee. The respondents were recruited from the lists of members of the World Health Organization's health working groups and Health Cluster hubs in Amman and Gaziantep, and additional individuals were identified through snowball sampling. Interviews were conducted in January and February 2017.

The interviews were conducted using a semi-structured guide. The guide asked respondents about their role within their organization, services provided by their organization, and what ethical challenges their organization had faced while providing or supporting the provision of health services in Syria. No audio-recording equipment was used, as the goal of the organizational manager interviews was to capture major themes and guide the development of subsequent study phases. All but 12 interviews were conducted in English. Eight were conducted in Arabic and four in English and Arabic. Those conducted in Arabic were translated into English by members of the study team fluent in both languages. Interview notes were recorded by hand or typed.

Most of the respondents were affiliated with NGOs providing or supporting health services in opposition-controlled areas, though some worked in government-controlled areas. Using the guide, we asked generally about ethical challenges and then probed about the particular challenges they faced because of the high level of violence they worked within. After completion of the interviews, qualitative content analysis was performed by the interviewers themselves and other members of the study team to analyze content, and to identify emerging themes.

C | FRONT-LINE HEALTHWORKER INTERVIEWS

We conducted 58 in-depth interviews with front-line health providers working inside Syria. We used maximum variation sampling to represent a range of types of health work and used snowball sampling to facilitate recruitment of individuals working in hard-to-access communities. Snowball sampling drew on participants' knowledge of the health assistance landscape. Twenty entities were represented in the interviews, including eight international NGOs, seven Syrian NGOs and five from a mixed category that includes health directorates. Respondents included 43 people (36 men and 7 women) in northwestern Syria and 15 people (8 men and 7 women) in southern Syria. Thirty-nine of the respondents were hospital-based. Slightly fewer than half the respondents were physicians. Others included nurses, managers, pharmacists, lab technicians and others. Respondents working with Syrian and international NGOs were equally represented. Those interviewed may not be representative of all Syrians.

Interviewers were trained face-to-face by study team members, using a four-part PowerPoint presentation covering all aspects of the interview that interviewers could use as a guide. The Gaziantep-based interviewer observed five interviews conducted by a senior study team member experienced in qualitative interviewing and his first interview was observed by two senior study team members.

After obtaining their verbal consent, the respondents were asked open-ended questions using a semi-structured guide translated in Arabic and back-translated into English. Respondents were asked about the violence they experienced in the course of their work, the challenges they faced as a result of the violence they worked within, how they addressed those challenges, and the impact of violence on health services they were involved in and their own lives. The questions about challenges were open-ended to encompass a variety of responses and also included prompts to orient

individuals to ethical challenges. These prompts were examples of concrete ethical challenges provided by key informants in the previous round of data collection and were posed as examples of problems individuals might have faced in their work. Interview questions did not define ethical challenges or ask the respondent to do so, nor did they reference specific ethical or humanitarian principles.

Interviews took place from June 2017 to June 2018. All but a handful of interviews were conducted remotely with health workers in Syria by Syrians who are native Arabic speakers via a secure communication app. Interviews lasted on average 60–90 minutes. With the respondent's permission, the interviews were recorded, then transcribed in Arabic and translated into English by an independent firm. In the five cases where permission to record was not given, the interviewer took notes in Arabic, which were translated into English. This was done to keep the conversation grounded in concrete examples and to maintain an inductive approach.

A codebook was inductively developed using NVivo 11 software. Inter-rater reliability was achieved to above 85% consensus among three coders. The coders also wrote memos to explore coded text and identify major themes and relationships. The initial codebook included codes developed from the key informant analysis and was then revised after coders read and coded an initial set of transcripts. Interviews were qualitatively coded for key themes and queries were run to further examine the content of themes.

D | WORKSHOPS

We held two 2-day workshops in June 2018, one in Gaziantep for northwestern Syria and one in Amman for southern Syria. At the workshops we reviewed the findings of the interviews and literature review with individuals who had first-hand knowledge of the challenges facing international and Syria NGOs, health directorates and front line health workers in Syria. After hearing about and discussing findings, workshop participants were asked to reflect on

the findings as well as their own experience to determine what type of practical recommendations and implementation steps would most help front-line health workers, on-site managers, and NGOs to address the ethical challenges they face.

The Gaziantep workshop included four health workers working in northwestern Syria, one representative from a UN agency, three international NGOs, two Syrian NGOs and two health directorates. It also included four researchers from Johns Hopkins, and three SAMS staff. Participants were a mix of physicians, nurses, clinicians and health outreach workers working inside Syria, as well as program coordinators, administrators, health and nutrition officers and protection officers working inside Syria. Because of intensified conflict in southern Syria and border closures into Jordan, the Amman workshop was attended mainly by international NGOs and UN agencies based in Amman. The total number of participants was 13, including three from Johns Hopkins, five from IRC, one from UNHCR, and five from other international NGOs. Three participants were female and ten were male.

The scenarios involved decisions concerning maintaining the quality of care in the face of violence that diminished the capacity of hospitals to meet standards of care, closure of hospital on account of violence, maintenance of impartiality in the face of armed groups' demands for priority in treatment, and psychosocial support for staff. For each scenario, the following questions were posed to participants:

- What is at stake here? What is the nature of the challenge?
- Who is going to be hurt/helped by a decision?
- What is the severity of the harm to those hurt?
- What is at stake in the resolution of the problem in terms of benefits/harms, severity, and other factors?
- In the process, what are the principles at stake for the organization and its responsibilities to people?
- What consultations and input are important, if any?

In the last phase of the workshops the group reviewed two existing proposed guidelines and tools for addressing ethical challenges in humanitarian health practice and discussion of their appropriateness and usefulness in the Syrian context. These were the Humanitarian Health Ethics Analysis Tool (HHEAT)¹⁶ and another proposed by Clarinval and Biller-Andorno.¹⁷ Each of these tools provides a guide for a process for humanitarian health organizations to address ethical challenges in a systematic, step-wise approach, and ones that encourage group discussion and collaboration in making decisions on difficult ethical challenges.

Although neither was created for the purpose of ethical decision-making in settings of extreme

violence, their focus on humanitarian action more generally suggested that they would be worth considering in this context. These two tools were examined in detail in the workshops. These tools do not point the way toward the resolution of a particular question but set out a process for ensuring that relevant ethical considerations and factors are considered in the decision, and that the process of decision-making is systematic and clear. Each of the tools is designed to help decision-makers assess the values at stake, the facts and circumstances that make it difficult to adhere to all the values, assess harms from various courses of action, and then arrive at a rational, if difficult decision.

The tools can be summarized as follows:

10 STEPS (from Clarinval and Biller-Andorno¹⁷)	DESCRIPTION
1. Gather evidence	What are the facts ? And who is affected?
2. State the ethical values and principles	What ethical and humanitarian principles are involved?
3. Examine arguments	State clearly what the ethical tension is
4. Define options	What decisions could you make?
5. Weigh the options	What are the advantages and disadvantages of each option?
6. Elaborate decision	Make your decision
7. Justify the decision	State why you made that decision
8. Implement the decision	
9. Monitor and evaluate the outcome	How will you know if your decision was correct? (Indicators and metrics)
10. Make recommendations for future actions	Can you prevent this from happening in the future?

¹⁶ Fraser V, Hunt, MR, De Laat S, Schwartz L. The development of a humanitarian health ethics analysis tool. *Prehosp Disaster Med* 2015; **30**: 412–20. See also: Fraser V, Hunt MR, Schwartz L, De Laat S. Humanitarian Health Ethics Analysis Tool: HHEAT handbook, 2014. <https://humanitarianhealthethics.net>.

¹⁷ Clarinval C, Biller-Andorno N. Challenging operations: an ethical framework to assist humanitarian aid workers in their decision-making processes. *PLOS Currents Disasters* 2014, edition 1. doi: 10.1371/currents.dis.96bec99f13800a8059bb5b5a82028bbf.

HHEAT: Humanitarian Health Ethics Analysis Tool

<p>1. Identify/Clarify Ethical Issue What is at stake and for whom?</p>	<p>Is it really an ethical issue? What is at stake and for whom? How is the issue perceived from different perspectives? When must a decision be made? Who is responsible for making it? What has been done so far?</p>
<p>2. Gather Information What do we need to know to assess the issue?</p>	<p>What information is needed to deliberate well about this issue and enable us to make a well-considered decision? What constraints to information gathering exist? Consider: (a) Resource Allocation and Clinical Features (b) Participation, Perspectives and Power (c) Community, Projects and Policies</p>
<p>3. Review Ethical Issue Does information gathered lead us to reformulate the issue?</p>	<p>Does the process so far reveal new aspects of the ethical issue or suggest the need to reformulate or redefine the issue? Have our biases/interests affected how we see the issue?</p>
<p>4. Explore Ethics Resources What can help us make a decision?</p>	<p>What values and norms ought to inform our decision making? Consider: professional moral norms and guidelines for healthcare practice; human rights and international law; ethical theory; local norms, values and customs.</p>
<p>5. Evaluate & Select the Best Option What options are possible and which is the “best” under the circumstances?</p>	<p>What options are possible in this situation and what ethical values support each option? What consequences might result from each option? Can consequences, values and obligations be reconciled?</p>
<p>6. Follow-Up What can we learn from this situation and what supports are needed?</p>	<p>What can we learn from this situation? What support do those involved need?</p>

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III. FINDINGS

A | LITERATURE REVIEW

A total of 66 out of a possible 2,077 peer-reviewed publications met our inclusion criteria. The review yielded eight ethical obligations stemming from ethical principles, contained in Table 1 below. Most frequently noted ethical challenges, measured by the number of instances of coding, for organizations working in the setting of violence were related to (1) providing the highest attainable quality of care, (2) properly managing assets, and (3) protecting and caring for health workers. Other ethical challenges emerging from the review related to distributing benefits and burdens equitably, incorporating local knowledge and recognition of cultural norms, and minimizing harms of response, honesty and transparency in communication and interactions with communities and beneficiaries. The most frequently noted humanitarian principle that was challenging to uphold was neutrality, followed by independence, humanity, impartiality and solidarity.

The review revealed how humanitarian principles both complement and supplement ethical principles. The humanitarian principle of impartiality, for example, relates to the ethical principle of justice by prohibiting discrimination based on ethically-irrelevant characteristics. Similarly, the humanitarian principle of humanity appears to relate to beneficence in emphasizing relief of suffering.

In other instances, there can be tension between these two sets of principles. For example, a humanitarian organization's obligation to protect its workers may require resources that take away from aid delivery that could relieve more suffering. Supporting a locally-led response could jeopardize

the perceived independence of the organization if locals are aligned with one side or another in a conflict.

The relationships we observed between ethical and humanitarian principles suggest that decision-making frameworks for ethics can apply to decisions involving challenges to humanitarian principles. The literature review also revealed strategies that groups have used to fulfill their ethical and humanitarian obligations. Table 1 provides some examples. The arrows show as well that a strategy to fulfill one obligation may also influence another (though it is also the case that adopting one strategy does not always map positively onto other strategies and obligations):

B | ORGANIZATIONAL MANAGER INTERVIEWS

The following themes emerged in the interviews:¹⁸

Attacks on health facilities and workers, requiring them to balance the safety of their staff and patients while under attack with the obligation to provide care to the communities they serve. For example, given the dangers to hospitals, multiple respondents reported that they had to make decisions on whether to limit the length of patient's stays, which could compromise their health status, decreasing the number of staff in the facility, which could affect the quality of care, or decentralizing decision-making. Some respondents spoke to the problem of risk transfer to community-based organizations. Managers also noted the consequences of closing facilities, which caused stresses on remaining ones. Some respondents noted, too, that violence affected their relationships with communities, some of which did not want hospitals in the vicinity because of the risks of attack, which could affect the whole community, even if the facilities improved access to care.

Access restrictions, including border closings and Syrian government restrictions on passage, which

OBLIGATION	STRATEGY
Providing the highest attainable quality of care	Training local workers to deliver care to people in need, rather than relying only on the organization
Protecting workers	Developing a plan for worker safety (MSF “Medical Care Under Fire”)
Minimizing (unintentional) harms of relief work	Including affected groups in the planning process to anticipate harms
Supporting a locally led response	Promoting conversation with the local community before, during, and after a response
Organizational resource management	Using locally purchased supplies wherever possible, rather than relying on shipments
Distributing benefits and burdens fairly	Prioritize those in need, not just those easiest to access (even if it means lost efficiency)
Honest and transparent communication	Develop a formal chain of communication
Incorporating local knowledge and norms	Ensuring beneficiaries are involved

Table 1: Ethical principles and challenges

both limited the ability to provide supplies and medications, and restricted training opportunities and monitoring programs in the field. One respondent with a donor organization said the restrictions challenged its ability to be accountable to stakeholders as it could not properly assess how funds were spent and services managed and delivered.

Resource limitations, including staff shortages, lack of qualified staff, and limited bed capacity in facilities. Multiple respondents identified difficult decisions resulting from these shortages, such as how to provide services equitably, support health providers acting beyond their professional training, and address health needs beyond acute injuries.

The resource shortages also raised challenges in adhering to standards of quality of care.

Demands of governing authorities and armed groups, which could compromise neutrality, impartiality, independence, and ability to protect patients from harm. Many respondents raised concerns about the implications of registering (or not registering) with the Syrian government. Many respondents also identified demands by armed groups to hire particular people and to give priority to certain patients.

Cultural norms, such as challenges in respecting norms while providing equal and appropriate services for women’s health when few female

¹⁸ For a more extended description of the results of the key informant interviews see Funk K, Rayes D, Rubenstein LS, et al. Ethical challenges among humanitarian organizations: insights from the response to the Syria conflict. In: Ahmad A and Smith J, eds, Humanitarian actions and ethics. London: Zed Books, 2018.

providers were available. When services were provided by females, organizations faced challenges in addressing harassment and gender-based violence against female staff.

Demands of donors, such as challenges of adhering to funding restrictions and accountability standards that could limit essential services organizations felt a duty to provide.

C | FRONT-LINE HEALTHWORKER INTERVIEWS

The following themes emerged from the front-line health worker interviews, listed in descending order based on the frequency which they appeared in the interviews:

- Support from the organization in making difficult decisions
- Not enough qualified health workers
- Psychological burdens and concerns
- Disruptions in service provision
- Attacks on health facilities and services
- Access to medical resources, equipment, or supplies
- Family-related challenges
- Shortage of staff
- Relocating health facilities

In addition, women respondents raised gender issues. To provide context for the findings, we begin with the theme of attacks on health facilities and personnel, then discuss consequences for health care provision and, finally, focus on the health workers personally. Within each theme, we address steps, if any, respondents have taken to cope with the challenges they face.

Attacks on health facilities and workers:

Respondents reported attacks or assaults, including aerial bombings, rockets, sieges, roadblocks, and seizures of materials at times during the war. Of these, bombings were the hardest to endure, as attacks were often unpredictable and uncontrollable,

“When the people were dying before us, you feel that the profession of medicine is a human profession. At such times, we feel we need to be near our people, our neighbors.”

with little advance warning, and often caused catastrophic structural damage and bodily harm. Situations of close combat or attacks on individual workers were infrequently described during later periods of the war.

Respondents described feeling unsafe and uncertain during periods of attack. Respondents in managerial positions experienced challenges in asking their staff to be exposed to violence and increased risk during periods of aerial attacks, as during these episodes staff services were most needed. They had special concerns for staff with families and described having to make difficult decisions about whether to expose surgeons to increased risk of loss of life.

Many respondents explained that they chose to remain in Syria despite the risks out of a sense of moral duty and a desire to save lives. One said:

When the people were dying before us, you feel that the profession of medicine is a human profession. At such times, we feel we need to be near our people, our neighbors.

Another said:

When you see the massacres that were taking place (things are getting better now), you do not ask for your safety. When you see cut limbs or someone carrying a severely injured son, the last thing you think about is your safety.

Respondents also expressed a sense of responsibility or duty to help their country. Several emphasized that their decision to remain was not motivated by salaries, and some reported that they had to ignore “financial temptations abroad.”

A number of respondents reported that attacks on hospitals created tensions with communities. One said:

The people living near the hospital are upset every time there is artillery bombardment. They consider the hospital to be the cause, despite the fact that they take medicines from the hospital free of charge.

Almost all respondents expressed a commitment to medical impartiality. One said:

I know my country is more than opposition or supporters, in fact, we are 24 million human beings, so we are more than supporters and opposition... as a part of people, we have to behave as people. I consider myself neither an opponent nor a supporter—I'm a doctor of these people and I don't differentiate. I worked on so many operations, in fact on those captured, and for people I know, and who I don't know them, no problem.

Some respondents said they did not face interference in medical care by armed groups because they perceived that the medical staff treated people as patients, not as fighters or civilians. However, other respondents described verbal threats, harassment, humiliation, and incidents of violence. One respondent described an incident where an armed group shot at a doctor and threatened to kill him for prioritizing the care of a patient already undergoing treatment rather than attending to their wounded compatriot. Another respondent said that a challenge,

which concerns us as a team, was the lack of respect and threats from the fighters. And dealing with these challenges was difficult—once a doctor left the job and no one could convince him to remain, because he could not bear the humiliation of the fighters, and later ISIS controlled the region. Most of the medical staff, including I, left work.

Another respondent described an incident where

We asked the wounded man to be patient till we finish another. They got angry and threatened us with a weapon. I was very afraid, and I did not know how to work—I felt they would shoot bullets in the hospital. So, I left the patient whom I was treating, and I hid.

A few respondents described pressures from ISIS to work under strict rules and to follow its demands regarding service delivery, risking punishment if staff didn't comply with orders.

“ We asked the wounded man to be patient till we finish another. They got angry and threatened us with a weapon. I was very afraid, and I did not know how to work—I felt they would shoot bullets in the hospital. So, I left the patient whom I was treating, and I hid.

Respondents cited a variety of strategies to cope with the challenges they faced as a result of the violence. With respect to security, respondents said they engaged in disaster readiness and preparedness, fortifying and relocating facilities, stockpiling medications and equipment, transferring patients elsewhere, and keeping locations of facilities and ambulances secret. Respondents also cited the benefits of coordination with local councils and communication with communities to address their concerns and build trust. One said:

We provide services and when performing a good service for people, people will support us. When we treat people well and provide good service, then we will not be exposed to military pressure and problems. We always deal with civil local councils and they, in turn, getting along with the military and solve problems.

Respondents identified several other strategies to deal with threats and interference from armed groups, including installing security guards at hospitals, having management teams handle conflicts, complaining to a soldier's superior and seeking an apology, developing a complaint system for civilians being treated poorly in the community, and demonstrating impartiality to armed groups:

We have a guard at the gate, who prevents any weapon [from entering] inside, so this can help protect the cadre. Another important thing is that we are also providing humanitarian services without bias and impartially. The employing of the people from the area is helping. They know each other and can solve problems. Once we have the position that one of the fighters was intent on violence with one of our cadre, but the locals in the area who worked with us stood against him.

Disruption in service provision: Respondents reported that during and in the aftermath of attacks, services deteriorated and were often limited to critical care due to the loss of equipment and supplies, injury or death of health workers, and disruptions to supply lines, access routes, and electricity/utilities. As a result, in such cases trauma/emergency medicine was typically prioritized. Elective surgeries were postponed, canceled, or performed by non-specialists. Patients were sometimes prematurely discharged to remove them from the danger of further shelling or bombing of the facility. Patients with health problems that were deemed minor or non-urgent were discouraged from seeking care. Respondents expressed a desire for more guidance on when and how to pause or shut down non-emergency services, or facilities themselves, during and after periods of attack.

About a quarter of respondents described community outreach programs their organizations or facilities coordinated. These programs included public health activities such as infectious disease control programs, information campaigns to improve maternal and child health around breast-feeding and child malnutrition, and vaccination campaigns. Community health workers visited homes to provide education about safe delivery practices. One said:

The project of the mobile teams was done—about 324 volunteers...doctors, health staff, nurses and health workers were touring all the shelters and the cellars and provided health services and primary health care for the people in shelters...They were used to look after the children and follow up on their nutritional status in order to find out who were undernourished to give them the existing nutritional supplements.

These strategies, however, were also disrupted by the violence inflicted on health care and communities. One said: “Firstly, I mention here the vaccine campaigns. As soon as we had a mobile campaign of vaccination, the regime was targeting the areas where we worked.” Another explained, “After ISIS control, we were exposed to pressure. I

“We have changed our places many times because of the fear of bombing...We have moved about four or five times because of the security situation, shelling, and air strikes. And civilians always [told] us they do not want to have a medical center or hospital next to them. We understand their fears of the shelling.”

mean, the strategy of the [vaccination] campaign from house-to-house—they were canceled. ISIS considered them as a security issue.”

Relocating health facilities: Relocation of facilities or moving them underground created special challenges in limiting services. If instead managers sought to rebuild or rehabilitate facilities, additional resources and support such as finances, supplies, labor, and guidance were needed. Respondents also described challenges in accessing utilities and supplies in new locations, as well as increased psychological distress of health workers working in hidden and underground locations for long periods.

In some cases, communities objected to relocating field hospitals in their vicinity. One respondent explained:

We have changed our places many times because of the fear of bombing...We have moved about four or five times because of the security situation, shelling, and air strikes. And civilians always [told] us they do not want to have a medical center or hospital next to them. We understand their fears of the shelling.

Another said:

This moral dilemma is not solved. We have two options: either to keep away from people, so that the surrounding [area] is not affected by the shelling when planes target the [facility], but it is difficult for people to reach us as we have moved away from them.

Coordination with other medical facilities and NGO headquarters was often delayed or interrupted during or after attacks and when staff were forced to relocate. One respondent explained:

In the recent period, events have accelerated significantly and communicating with organizations and external agencies was originally difficult...there was no time to tell anyone that you want to move, even there was no Internet connection and the Internet became very bad [and] communication lines were very weak...What happened was that when the hospital was targeted, we had to vacate the place quickly and move to another one...We have to leave, and it might happen within hours without prior coordination at all.

Challenges in providing quality services:

Respondents described deterioration in the quality of services they could provide, especially in the early years of the conflict. Many facilities were not equipped to handle the high volume or severity of emergency cases coming in after a bombardment. In some cases, injuries were more catastrophic than the facility had the capacity to address. Even with fewer intact and functioning facilities and staff shortages, hospitals were forced to provide services beyond what they were designed for, all of which affected quality. Many respondents described not being able to save patients. They also identified less obvious challenges in maintaining quality such as inability to transfer patients to facilities with the skills and resources to treat them.

Respondents also described inequity in access to quality care, with hospitals near the Turkish border in northwestern Syria are better equipped, more able to attract and retain higher qualified staff, and with more reliable access to supplies than those deeper in Syria.

Primary care in field hospitals was often sacrificed, respondents said, and some primary care facilities were converted to trauma care, even as communicable diseases that had previously been eradicated from the country started to spread. In some facilities, chronic conditions requiring specialized treatment were left untreated, and mental health services were often not offered. In heightened security situations, patients were sometimes discouraged from traveling to health centers for care in all but the most critical cases.

Respondents described difficulties in managing these shifts and how to support primary health needs, including reproductive health, given the protracted nature of the conflict. Respondents also talked about the prevalence of Cesarean sections in deliveries as a means of lessening the time in the hospital.

Physicians also spoke about how they had to shut down other services because of external conditions. In other cases, they had to use strict triage protocols that focused on the likelihood of survival rather than the need for intervention

One respondent said that as a result of these constraints, “reality makes our decisions,” suggesting that there were few options, with decisions dictated by circumstances.

In most cases, respondents considered that limited or lower quality care was better than none at all. This was particularly the case at the start of the conflict when new systems to cope with the impact of the conflict had not been organized.

To address quality of care concerns, some doctors performed their own research to develop new clinical protocols for limited resource contexts, for example to find alternatives for drugs they did not have. Others received input from donor organizations on how to deal with certain cases—however, these were typically ad hoc decisions made while continuing to be overwhelmed by mass trauma. As noted in more detail below, these decisions contributed to the psychological stress health providers experienced.

Doctors expressed a commitment to maintaining medical and clinical ethics, including impartial treatment, adhering to clinical protocols as much as possible given resource limitations, and treating all patients in need, even if affiliated with a political organization. They insisted that other staff do the same. In some cases, though, follow-up was not possible. One said:

The nurse in the room told me that this person is a [captured] soldier of the regime, but I told the nurse that it is not our business, even if he was a prisoner-of-war, I am not a judge. I took him to the emergency room, we moved him to the operation room, and operated on his wounds, and by the second day he got well and started to talk with us. But I couldn't follow up his state—I don't know where he went because I'm a doctor, still a doctor.

Some respondents described trying to respond by meeting the health needs of patients beyond strictly medical care. One respondent cited the stockpiling vitamins to address the effects of limited or no access to fruits during the siege in Aleppo. Vitamins and medicines were distributed based on social vulnerability, that is, more would be given to a woman responsible for a family than to a young man who can more easily support himself and his family.

Lack of qualified health workers, staff shortages and task shifting: Respondents identified shortages of qualified health workers as a particularly important challenge. Many qualified health workers were displaced from Syria due to the conflict or were deterred from working in demanding and risk-prone areas. In other cases, security risks prevented health workers from traveling to areas where they were needed. Some left the practice of medicine altogether. Interruption of recruitment and hiring due to active conflict made it difficult to fill the positions of those who left. Additionally, some respondents described biased hiring procedures due to pressure from local factions or armed groups. As a result, certain staff provided services beyond or outside their training and clinical competencies, which provided challenges for clinical and facility management and deterred patients from coming for services and self-treating. One respondent said:

We see death because of the bombing, but some people die because of heart disease, pressure and diabetes...Before, the patient used to visit a specialist doctor when there was a problem, but people have been dealing with the disease in primitive ways, I mean, if he has a stomach ache, he goes to the

“ We see death because of the bombing, but some people die because of heart disease, pressure and diabetes...Before, the patient used to visit a specialist doctor when there was a problem, but people have been dealing with the disease in primitive ways, I mean, if he has a stomach ache, he goes to the drugstore asking for medicines. He does not think of going to hospital, possibly because the patient is not confident in the quality of the medical service provided by the hospital—there are few specialist doctors and some doctors have not graduated.

drugstore asking for medicines. He does not think of going to hospital, possibly because the patient is not confident in the quality of the medical service provided by the hospital—there are few specialist doctors and some doctors have not graduated.

However, as one respondent noted, patients showed respect for services offered: “The nature of the beneficiaries means that 95% of the people who follow the services respect the services, because they need them.”

To address skills shortages and task-shifting, many respondents cited in-person and online training as a means to maintain and develop skills, enable staff to take on tasks that were not part of their training, and address the complex medical conditions surgeons faced. As the conflict continued, respondents reported the training helped staff develop new skills and occupy new roles. Some facilities had resources to bring in specialists.

Limited access to supplies: Despite efforts of entities outside Syria to keep supplies up, at times and in certain places, access to medical equipment and medicine was limited. Equipment and supplies were sometimes randomly or irregularly distributed, often at insufficient levels. Transport of supplies was risky as supply routes were unreliable due to delays at borders or area control checks, destruction of supplies in transit, and sieges.

To cope, some respondents said, medicines and supplies were often stockpiled elsewhere for safer storage so that they would not be destroyed in an aerial attack. However, stockpiling was itself risky, as stores could be hit by airstrikes or taken over by government forces. Additionally, respondents reported that thefts and disputes over ownership of supplies occurred. Respondents in southern Syria explained that they received their medicines from Jordan, often major delays because of limited border crossings and difficulties in clearance.

Challenges in making difficult medical and facility decisions, and complexities of support from NGO headquarters and partners: International and Syrian NGOs running or supporting health facilities and personnel from outside Syria provided material and financial support, as well assisting with hiring, training, and higher-level decision-making. But some respondents believed that the support remained insufficient, and others explained that management staff or partner organizations were usually too far removed to be able to advise and guide health workers in real-time or with direct knowledge of on-the-ground events and circumstances.

Additionally, comprehensive policies to address critical and emergent issues to guide decision-making were often missing. For example, there were few guidelines to address changes in local security and impacts on organizing operations, relocating facilities, limiting, pausing, or shutting down services, re-instating services, transitioning to primary and routine health services/chronic illness management, prioritizing treatments and patients, coping with high volumes of trauma cases, managing under-qualified staff, addressing staffing policies and staff turnovers, addressing the role of local populations in facility decision-making and re-location, and advising on intervention/negotiation with military or paramilitary groups. Lack of clarity on organizational policies caused significant stress for health workers.

Respondents explained that it was difficult to plan ahead or coordinate their work effectively.

“ [Our organization] did not care about us. I did not know the idea of their job—they were paying salaries and medicines, but they did not ask about our needs, on the contrary, they assess our needs without asking us and this was very bad.

Emergency measures in response to attacks were often ad hoc. Most respondents said that staff on the ground felt that they were best able to make certain decisions, e.g., when to close and re-open hospitals or how to staff hospitals while under attack, given their direct proximity to events, and that headquarters recognized that. Health workers thus had a certain degree of freedom and independence, but also experienced pressure to make decisions on their own in difficult circumstances. Some felt abandoned by their organizations at critical times.

Although most respondents spoke positively of their headquarters, some did not feel adequately supported by them or experienced tensions with partners that provided funding and support to Syrian NGOs. Some field-based health workers mistrusted larger NGOs and donors. Some respondents reported that they experienced intermittent, low, or no pay during the conflict, and objected to lack of compensation for families in cases of injury or death of a health worker. One said,

[Our organization] did not care about us. I did not know the idea of their job—they were paying salaries and medicines, but they did not ask about our needs, on the contrary, they assess our needs without asking us and this was very bad.

Additionally, respondents described a lack of psychological services or support for staff, a lack of training programs, and the inability of some staff to travel to Turkey for breaks and training.

Some respondents felt that they were forced to take on managerial duties given staff shortages when they did not want to be responsible for difficult decisions, such as penalizing staff for missing work

knowing that staff were afraid to come to work. A few respondents thought that organizations did not adequately support impartial care. One said that

a moral challenge we faced as a medical team is when we ask for support from some organizations. We knew later that these organizations refuse us because we are receiving large quantities of fighters.

Women respondents noted that organizational support for addressing gender discrimination, which sometimes created increased risk to them, was often lacking. One explained:

We, as women, work in the hospital, our main problem is transportation. We are in a rural area. We cannot move easily by virtue of the traditions of the community. There must always be some male to accompany us, and this causes a delay to arrive at the hospital or in the return to home. We have asked for a lot of times for transportation, but unfortunately, they say that the grants do not cover transportation fees.

Female nurses said they were often not allowed to touch male patients or patients might refuse treatment if the health worker was a woman. One respondent said:

Someone came and obligated us to do a surgery or such thing. As a female, I could not face a man and convince him. I always face these problems.

Dealing with members of armed groups was often particularly difficult for women. One said:

I suffered from this issue a lot as a female not [allowed] to touch a male patient, it is haram [forbidden]...most of the time for the militants, he prefers to be bleeding and not to touch him or treat his wound or give first aid until a male doctor comes.

Finally, female staff sometimes had to contend with less respect for their professional skills, lower salaries and the challenge of balancing work and family responsibilities. One said:

I feel that is part of our society...[they] consider women to be less than men and they believe that in medicine, female doctors do not know as much as male doctors. It exists in a part of society.

Another noted:

...we are in an Eastern society, there is a clear distinction in favor of males in administrative positions and salaries...some female nurses have strong experience, but when there is an appointment, it is impossible to meet a female nurse in charge in the nursing department, or a director. And even with salaries, there is a distinction. Of the other difficulties, sometimes there is no consideration that the woman has a house and children or family. Sometimes there are night shifts or in inappropriate times to our status as women.

Psychological burdens: The conditions of practicing medicine in extreme violence, as well as the need to make such decisions that the respondents believed compromised their commitment to principles of humanity and impartiality, and without protocols or support, caused considerable psychological distress and guilt.

Many respondents described the burdens of putting aside their own fears of attack and death and punishing working hours in order to fulfill a sense of duty. One said:

Frankly, [these conditions] have had bad results on our output at work and my psychology as a doctor, but choices are limited like all people, we can't leave people with no help, so when we come to the hospital we do our best with all energy. We are working 15 hours a day or more, it affects so much on our psyche and mood, but options are limited.

Many respondents described moral distress in having to make wrenching life-and-death decisions and work at considerable risk of harm to themselves and their colleagues, while feeling that they were not doing what were called for medically. They described often feeling overwhelmed by the difficult decisions they were forced to make. One said:

II *I suffered from this issue a lot as a female not [allowed] to touch a male patient, it is haram [forbidden]...most of the time for the militants, he prefers to be bleeding and not to touch him or treat his wound or give first aid until a male doctor comes*

// *I knew what people needed but I couldn't provide them with. I was devastated. I took the responsibility and people were relying on me, so when I couldn't provide the service to them I was devastated, it was a huge psychological burden.*

I knew what people needed but I couldn't provide them with. I was devastated. I took the responsibility and people were relying on me, so when I couldn't provide the service to them I was devastated, it was a huge psychological burden.

Another said:

I am subjected to constant punishment and self-lashing continuously without interruption. I am actually doing humanitarian work and help the wounded and save the lives of people, but the situation continues. Every day someone dies—we cannot save lives because there is no possibility. This is the biggest ethical challenge I can ever speak about. We have been living in this state for many years. Sometimes I think really, how do I eat, drink, and live, and think about the bombing and the people who died, with the sense that my mind will explode...When a wounded [person] dies and his family starts weeping on him in the hospital, I feel guilty, sometimes I feel that I killed him because I could not help.

Another said:

You are a doctor—you want to save as [many] people [as] you can and there would be people you have to decide they will die at that moment, so it was the hardest and painful moment to feel you have to leave people to die because you can't serve all. You have to leave critical cases to die and take other cases you think will have better chance to live and you try to help them. That is the most painful thing.

It was especially wrenching for doctors to have to tell families that their children could not be saved, so would not get care. One said:

The painful point is that parents asked you to do your best—they asked you to help their kids. They are right, but you have to care who may survive and give aid for him, not who has no chance to

survive. People don't know this fact—they can't realize that their kid has no chance to survive—they want their kids to still alive if it is possible. They are right, but we are obligated, according to our knowledge, we help and do our best for the one we think will survive.

Some respondents explained the burden of decisions to prioritize treating surgeons or doctors, as the loss of these lives would ultimately affect more people than the loss of one patient's life.

Respondents also described the psychological costs of shutting down services. One said:

When we made a decision to close the project, for example the decision of restoration of the National Hospital, where I have worked for about a year, I felt like I had lost one of my children. It is not an easy decision, but you are forced to do it. You have employees and you are responsible for them. You have patients who cannot afford it. You cannot put them at risk. You feel very responsible. When you make such a decision, you feel that it is a difficult decision and you are forced to take it in order to protect the safety of the people around you.

Respondents in northwestern Syria said that training in Turkey often provided a psychological break, but that they were not always granted leave for the training.

Family-related challenges: Respondents explained that their decision to provide health care in the war and their vulnerability to attack deeply affected their families. One said:

I chose to give up my private life in order to save more children or work in the absence of other doctors. I chose to leave my own life, or family, I chose to stay away from them and live in a dangerous area in a region where a person can die at any moment.

// *Even if one of us or our families are injured, who is going to help? All organizations easily give up the injured, leave them without salary or compensation, because he is unable to work. This point is very affecting.*

Another said:

As the nature of work at the family level, it affects very negatively on the house. I am married recently and there is bombing, and my wife is alone at home.

A few respondents expressed worry whether their families would be compensated if they were injured or killed in an attack:

Even if one of us or our families are injured, who is going to help? All organizations easily give up the injured, leave them without salary or compensation, because he is unable to work. This point is very affecting.

D | MAPPING EMPIRICAL FINDINGS ONTO OBLIGATIONS FLOWING FROM ETHICAL AND HUMANITARIAN PRINCIPLES

It is possible to map the empirical findings from onto the ethical and humanitarian principles to indicate how situations of extreme violence present challenges to the obligations that flow from ethical and humanitarian principles. Examples are provided in Table 2 (pages 27–28).¹⁹

E | WORKSHOPS

1. ETHICS AND ETHICAL CHALLENGES

The workshops held in Gaziantep and Amman reviewed the findings from the ethics literature review and the interviews, and then addressed possible recommendations. Workshop participants occupying all levels and roles were generally familiar with humanitarian principles. Clinicians especially described knowledge of medical ethics and its implications for their decisions on questions involving quality of care and impartiality. They saw a

need for more systematic discussion of and training ethics in organizational decision-making and in addressing the challenges they face.

The participants emphasized that the most difficult ethical challenges they have faced are a product of violations of the laws of war, particularly the infliction of violence against the wounded and sick, hospitals, and health workers. They believed that the resolution of most ethical concerns will never be satisfactory until the violence against health care ends.

Participants agreed that in northwestern Syria decisions regarding operations, staffing, and priorities are usually made jointly between organizational headquarters and front-line staff and NGOs, hospital or local health directorates in Syria. At the local level, decisions are usually made by teams, though hierarchies also exist. International and Syrian NGOs at the country management team level, usually based in Gaziantep, Turkey, usually defer the final decisions on critical matters, e.g., to close the hospital or transferring it to another safer area to the field staff onsite. There are usually good communication channels about these decisions, but participants said that management teams could better support these decisions through the affirmation of field staff's independence and guidance in a clear decision-making process.

Participants in the Amman workshops discussed how the lack of ability to cross the border means there is much less communication between management staff based outside Syria and field staff. Management staff in Amman often lacked access to current information and are sometimes unaware of what decisions are made and how they are made, which sometimes causing tension as to what equipment was needed and other programmatic matters.

¹⁹ Table 2 does not contain a complete list of overlapping ethics and humanitarian principles. Additionally, neutrality does not precisely correspond to the beneficence and, as explained in the text, may not in all circumstances advance beneficence in all circumstances.

ETHICAL PRINCIPLE; HUMANITARIAN PRINCIPLES ¹⁹	CONCRETE OBLIGATION	EXAMPLES OF CHALLENGES IN HUMANITARIAN SETTINGS OF EXTREME VIOLENCE
Respect for persons; Humanity	Incorporation of local knowledge and recognition of cultural norms	<ul style="list-style-type: none"> → Different, competing factions/groups make it difficult to determine who legitimately represents local norms and knowledge → The community may not take account of the need to serve all people → Cultural norms may devalue women or others
	Honesty and transparency in communication and interactions	<ul style="list-style-type: none"> → Potential security risks in transparency regarding the location of hospitals
Beneficence (and non-maleficence); Humanity [Neutrality]	Provide the highest attainable quality of care and services	<p>Quality compromised by:</p> <ul style="list-style-type: none"> → Violent attacks and interference → Disruption or shortage of medical supplies, personnel, electricity → Difficulties getting medicine and providers to front-line communities → Health workers engaging in practice beyond their training (because of shortages) → Patients cannot access services → Essential health services, e.g., primary care, not offered as trauma care is a priority → Early discharge or inappropriate procedures because of fear of attack → The difficulty of implementing accountability mechanisms to ensure quality because of security, communication or access issues → Coercion by parties to conflict to favor certain patients or refrain from providing services to others → Political allegiances of providers
	Minimize harms of response	<ul style="list-style-type: none"> → Closing/moving a hospital inevitably creates harm, but difficult to assess options that creates least harm → Keeping health facility open could lead to vulnerability to attack → Lack of fully qualified staff risks harm to patients → Triage and other health priorities inevitably hurt those who could be treated
	Protect and care for workers	<ul style="list-style-type: none"> → Organization cannot reasonably assure the safety of health workers in the field, and transfers risk to them → The organization has difficulty addressing the psycho-social needs of health workers → Contingency, safety, or emergency plans difficult → Violence against and devaluation of women and vulnerable groups → Health workers' families may not be compensated if the health worker is killed

ETHICAL PRINCIPLE; HUMANITARIAN PRINCIPLES ¹⁹	CONCRETE OBLIGATION	EXAMPLES OF CHALLENGES IN HUMANITARIAN SETTINGS OF EXTREME VIOLENCE
Justice (procedural); Humanity, Independence [Neutrality]	Support a locally-led response	<ul style="list-style-type: none"> → Difficulty in identifying a local leader or partner → Competing groups claim to represent the local response → Local actors may engage in corruption, mismanagement, or lack adherence to ethical and humanitarian values
Justice (distributive); Impartiality/ Independence	Distribute benefits and burdens equitably	<ul style="list-style-type: none"> → Primary and chronic disease care subordinated to trauma care → Health workers may receive priority in treatment → Violence or threats interfere with impartial care → Security conditions render it difficult to reach people equally → Donors favor a particular program or group → Triage based on survival not need → Insecurity prevents reaching those in need → Parties to conflict coerce decisions → Violence prevents operating independently → Donors impose requirements inconsistent with organizational judgments about equity
	Appropriate acquisition and management of assets	<ul style="list-style-type: none"> → Insecurity makes it difficult to secure, protect and account for assets → Corruption and bribe-seeking make it difficult to manage assets appropriately → Donors impose requirements that cannot be fulfilled → Insecurity makes it difficult to recruit and retain personnel → Favoritism undermines hiring personnel

Table 2: Ethical and humanitarian obligations and challenges

In making decisions, workshop` participants recognized that because of the violence, and the difficult choices resulting from it, decisions almost always will harm some individual or some group of patients or compromise of humanitarian and/or ethical principles, e.g., giving priority to fighters in order to avoid violence. The goal is to make decisions that have a rational basis and mitigate harm to the extent possible.

Additionally, In the Gaziantep workshop, female participants identified problematic gender dynamics,

both how female staff were treated by some males in their own organizations and how they were treated by some beneficiaries and community members. Several mentioned that male staff peers, as well as the community they were serving, did not expect females to be playing certain roles and harassed them for seeking to play them. Organizations have procedures for reporting gender-based violence and harassment, but participants said that there is insufficient training about them. They also said that a higher priority to be placed on these issues. Participants did not identify devaluation of women as

a product of the violence, but one participant noted that the longer the conflict went on, the weaker the efforts to address discrimination and violence against women have been.

Each decision to address an ethical challenge is context- and fact-specific, but discussion of the four scenarios presented show how the workshop discussion unfolded.

The first scenario concerned responses to bombing of hospitals and armed interference. They saw the question whether to close as a relatively straightforward a matter of examining facts and risks. The more complicated ethical challenges arose in knowing which steps to take once a decision is made to close a hospital, whether to relocate the facility in the vicinity of the damaged one, thus increasing access to care but also increasing the danger of having an attack in the community, or to move services further away, thus depriving communities of close access to care. There was a consensus that the community's views had to receive great weight in the decision but there are ambiguities in what constitutes a community and who is a legitimate representative of it.

The workshop also discussed responses to armed group interference in hospitals' operations, which sometimes included kidnapping of one of the staff. In some cases, staff members engaged in a strike to protest, but this action also resulted in depriving the community of services. Workshop participants felt a need for guidance in these situations.

The second scenario involved quality of care, where the participants found the findings of the interviews consistent with their experience. In the Gaziantep workshop, there was a strong feeling among participants that staff in the field, as well as health directorates, were addressing ethical challenges that arose from quality issues as best they could, and consistent with their understanding of their obligations, but that a more structured approach would be useful. In the Amman workshop, there was agreement that the constraints required deviations

from optimal practice. Participants expressed concern that management staff had no way of assessing quality because of the inability to cross the border, and yet considered "doing the best we can" or "saving lives" an insufficient standard for quality assessment because it has no defined metrics. In their view, quality standards and assessments must be in place to ensure appropriate care ethically and professionally even in the Syrian context. They agreed, though, that it is very difficult to determine what those standards should be, and how to apply them in meeting compelling needs for services like cancer treatment and rehabilitation of war injuries.

The third scenario addressed impartiality in care. There was consensus in both workshops that providers must adhere to the principle of impartiality and base priority in treatment on medical considerations alone. There was believed that sharing experience and ideas about responding when impartiality is challenged, such as by armed groups, is essential, and could also somewhat alleviate moral distress. Some of the responses are practical ones, such as tactics in negotiating with groups and individuals that seek to give priority to certain patients.

The fourth scenario concerned psychosocial support. Participants agreed that both psychological distress and moral distress were highly prevalent among front-line health workers, as well as among managers. Additionally, some also noted that the lack of safety of medical personnel in Syria put more stress on managers and staff as the number of healthcare workers who are willing to take the risk of working in Syria under such conditions diminished significantly. In the absence of ending the assaults, participants believed that NGOs and donors have a responsibility to address the problem and to provide psychological support to their workers.

2. PROCESSES AND STRUCTURES FOR ADDRESSING ETHICAL CHALLENGES

Participants believed organizations need guidance on processes for making ethically challenging

decisions and on criteria for making them, e.g., identifying principles at stake, identifying ways to balance harms and benefits of a particular course of action, and finding ways of mitigating harms would be valuable. There was consensus on a number of dimensions of such a process.

Dedicated staff or structure for addressing ethical challenges: Participants agreed that organizations should have a person on staff who acts as an ethical resource officer to help guide managers and staff through the process of addressing difficult ethical decisions. This could be someone designated as an ethics officer (a manager or employee) or an ethics committee.

Establishment of a process for addressing challenges: Participants agreed that organizations should establish a clear, transparent and efficient process for addressing the ethical challenges they and their staff face. The process should be designed so that the organizations can learn from their own past experience by documenting the decision-making process and outcomes. Organizations should be open with each other about the decisions they make and how they make them.

Training: Participants agreed that staff and managers should be trained in ethics, and in the process for making, documenting, and evaluating decisions.

Community engagement: Participants believed that community engagement is critical regarding decisions that affect them. They believed that wherever possible information should be shared

transparently and early in the process, and made aware of choices, constraints, and other factors. In most cases, substantial deference should be given to the wishes of communities, e.g., in opening a hospitals. But participants agreed that deference is not always practicable or appropriate, as community views can conflict with organizations' responsibilities to adhere to ethical and humanitarian principles. Organizations should surface these potential conflicts and consider them as part of the resolution of the challenge confronting them.

Tools for decision-making: The workshops strongly believed the HHEAT and guidelines would be helpful in decision-making. Amman workshop participants expressed a preference for the Clarinval/Biller-Andorno tool as more explicit in the steps to be taken and somewhat clearer in outlining a need to monitor the results of decisions, though participants agreed that either tool could be employed.

The role of partner organizations and donors: Participants agreed that partner organizations that support local health providers, as well as donors, have an important role to play in enabling organizations and medical staff working on the ground, whether Syrian NGOs, health directorates, hospital managers or others, to make sound ethical decisions. They thought that communication about these decisions sometimes is quite effective, but at other times absent, which can lead to different understandings and discomfort among the partner organizations concerning the resolution of the ethical challenge in which they are implicated.

IV. CONCLUSIONS AND RECOMMENDATIONS

A | CONCLUSIONS

The pervasive violence inflicted on health facilities in Syria has destroyed hospitals, killed health workers, patients and others, and severely impeded the provision of health care. For international and Syrian NGOs, health directorate and front-line health workers, the violence and the resulting constraints it imposes on health care provision has also led to extraordinarily difficult challenges in adhering to widely accepted ethical and humanitarian principles.

International and Syrian NGOs, health directorates and front-line health workers must make decisions whether and how to shut down services while seeking to meet their obligations to serve the community fully, equitably and with quality care. They must contend with government and armed groups' actions that interfere with their ethical commitments and principles of impartiality, independence and neutrality. They must decide levels of acceptable quality of care in the face of shortages of staff, supplies, medication and electricity, as well as medical staffs that may be performing tasks that are beyond their training and experience. They must deal with coordination, communication and timing issues that jeopardize sound management and planning of programs and use of assets. They must fulfill their obligations to respect the wishes of communities they serve but be mindful at times when deference may jeopardize commitments to other values. The organizations must find ways of meeting their obligations to promote the well-being of staff and their families in circumstances where the psychological and material stresses are enormous.

The empirical findings and the workshop discussions vividly illustrate that it is not possible to provide the “right” answers to the moral quandaries that have arisen for health care in Syria. No matter what decision is made, some group of patients or community members will be hurt, sometimes grievously. Nevertheless, the ethical and humanitarian principles discussed in this report provide a grounding for addressing those challenges. Structures are needed to ensure that key challenges are identified and well understood based on a full consideration of the facts, and that processes exist to weigh the options and make and share decisions.

The findings on which the recommendations are based are subject to certain limitations. The front-line health workers interviewed were primarily based in opposition-held areas of northwestern and southern Syria, with little representation from areas controlled by the Islamic State. The majority were hospital-based, so the findings may not be generalizable to primary health care facilities. Second, the recommendations were informed by interview and workshop participants, who were predominantly male. This gender imbalance among interview participants may reflect a broader gender imbalance in the health workforce inside and outside Syria during the war. In any event, there remains the possibility that the types of issues discussed and how they might be managed in decision-making could reflect gender bias. Finally, no beneficiaries were interviewed for this study. That perspective would have been useful. It is clear, though that key informants and front-line health workers recognized the importance of beneficiaries in addressing the ethical challenges raised.

B | RECOMMENDATIONS

The recommendations that follow are directed at international and Syrian NGOs, health directorates and front-line health workers. For NGOs, the recommendations are intended to apply to different levels of operations, usually characterized as macro

(global headquarters), meso (regional or country headquarters) and micro (field, i.e., inside Syria). Many organizations operate at multiple levels and decision making happens at different levels of the organization. We believe the recommendations can be adapted to other situations of extreme violence.

Because many of the recommendations concern the need for organizations to commit adequate resources—human, financial, and material—to carry out the activities described below, they are also germane to UN agencies and donors, including providing funding for financial support for injured workers and families of health workers killed, and psychosocial support.

Humanitarian organizations working at all levels in situations of extreme violence should:

1. COMMIT TIME AND RESOURCES TO ADDRESSING KEY ETHICAL ISSUES THE ORGANIZATION AND THE HEALTH PROFESSIONALS IT SUPPORTS FACE

A commitment should be expressed across the organization, at all levels at which the organization operates. Where organizations collaborate, they should commit to addressing challenging decisions together. Addressing health provision challenges through the lens of ethics can enable better decision-making and may be viewed as more trustworthy and legitimate by those involved and affected by it. Ethically-informed decision-making by NGOs can also help support health workers on the front lines of aid delivery by relieving some of the moral and psychological burden on them.

2. ARTICULATE CLEAR ETHICAL AND HUMANITARIAN PRINCIPLES AS A FOUNDATION TO ADDRESS THE CHALLENGES THEY FACE

These can be based on principles widely accepted in the humanitarian community, as set out in Table 2, and supplemented by the organization’s particular values and other principles related to particular circumstances, such as respect for privacy and liberty in response to disease outbreaks.²⁰ These and related ethical principles are by no means the only norms and values that can be used to address the ethical questions arising in humanitarian practice. Our hope is that even those who might take a different approach than the principle-based one might nevertheless agree that the ethical obligations we have articulated provide a sound framework for addressing the challenges organizations face. Additional resources are available for humanitarian health ethics.²¹

One humanitarian principle, neutrality, warrants particular consideration. As noted above, neutrality is generally considered a means of advancing other ethical and humanitarian principles including beneficence, justice, humanity and impartiality. In Syria, however, neutrality may neither be possible or necessary for many front-line health workers as a means to adhere to those principles. Some front-line health workers and health directorates are affiliated with or have sympathies with political organizations, so may not be considered neutral, but adhere to and act in accordance with principles of beneficence, justice, humanity and impartiality. It is noteworthy, too, that under international humanitarian law, the absence of a neutral stance does not deny health

²⁰ See, for example: World Health Organization. Ethical considerations in developing a public health response to pandemic influenza, 2007. https://apps.who.int/iris/bitstream/handle/10665/70006/WHO_CDS_EPR_GIP_2007.2_eng.pdf;jsessionid=ECB5D655A935739EEF75D22EA77DDCCE?sequence=1.

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²¹ See, for example, the website of the Humanitarian Health Ethics Research Group. <https://humanitarianhealthethics.net/2019/01/31/looking-for-hhe-resources-check-this-out/>

workers the protection and respect owed by all parties to the conflict. The law provides only that they lose protection if they commit, outside their humanitarian function, acts harmful to the enemy.

3. PROVIDE REGULAR TRAINING AND SUPPORT IN ETHICS TO STAFF WITHIN THE ORGANIZATION

This includes training on core ethics and humanitarian principles and any additional principles and values to which the organization is committed. The training should include at least the following content elements:

- Those principles and values to which the organizations is itself committed (2, above)
- Introduction to ethical decision-making processes within the organization (4, below)
- Explicit instruction in the phenomenon of moral distress (5, below)
- Tailored instruction in the unique historical and cultural context and previous experience at the site(s) where an organization operates

Training should include an initial session with materials providing an overview of ethical and humanitarian principles, with case examples/ problem scenarios in applying them. The training could be provided in a webinar, but opportunities for face-to-face discussion of case scenarios among participants is very helpful and should be used wherever possible. A brief handbook on ethical principles should be made to participants.

Training should take place when individuals come to work for an organization or begin to provide services in complex, violent environments, and ongoing refresher training should be arranged periodically both to serve as a review and an opportunity for participants to discuss ethical challenges they have encountered.

4. CREATE PROCESSES AND MECHANISMS WITHIN THE ORGANIZATION TO SUPPORT ETHICAL DECISION-MAKING AND RECORDING AND DISSEMINATING THE DECISIONS

Adopt decisional frameworks: Decisional frameworks enable decision-makers systematically to apply relevant principles to the facts and circumstances of the case. A structured approach is especially important where all relevant principles cannot be fulfilled. The Clarinval/Biller-Andorno and HHEAT frameworks have three key benefits. First, they recognize the importance of explicitly articulating the norms and values to which an organization or individual is committed and that can be used to guide behavior. Second, by approaching decisions in a structured process, the frameworks make it more likely that all relevant considerations and facts will be included and weighed. Third, when the decision process is documented, use of the frameworks can lead to continuous improvement over time as decision-makers learn from past experience.

It was apparent from the literature review, primary data collection, and the workshops that in applying the frameworks, the greatest concern is to understand the extent and severity of harms that will befall individuals and communities when a particular decision is made. We think a focus on what these harms are, as well as the comparative harms from various courses of action (as harms cannot be eliminated), and how they might be mitigated, is central to the decision-making process and should be explicit.

In applying the framework chosen, organizations should ensure consultations with communities that will be affected by the decision. Consultations should take place as early in the process and where possible in anticipation of the need to make the decision. Absent special circumstances, organizations should be transparent in the information they share and the decision that needs to be made. Respect for community wishes is important, while organizations

should recognize that deference to those wishes may not be appropriate based on logistical, programming or ethical considerations. In such cases, the conflicts should be acknowledged and addressed.

Create internal structure to facilitate and record decision making: Organizations should assign responsibility to a manager, management group, ethics committee or specially-assigned ethics officer to train staff, facilitate decision-making, create a repository of decisions, advise on using the frameworks, and liaise with other organizations. They should establish a mechanism to encourage reflection on ethical questions and to provide support for sound ethical decisions. There should be regular communication by the responsible person of the group with everyone in the organization. The structure should be transparent both within and outside the organization. Whatever mechanism is established, there should include opportunities for inclusive discussions among affected staff on both particular challenges and ethics generally. The structure should also recognize the need for gender balance and representation of national and international staff as well as management, administrative, clinical and social service staff.

Create mechanisms to ensure that the structure is easily accessible to employees, entities supported by the organization and their managers and staff: The structure should be designed to ensure that affected individuals can raise questions and bring ethical concerns forward through a process that is accessible, transparent and safe. The organization should communicate that no one who raises concerns about the organization's own practices or decisions will suffer negative consequences for having raised them.

International and Syrian NGOs that provide support from outside the country should engage with NGOs, front-line health workers and health directorates in Syria to establish means of communicating about and addressing ethical challenges.

Engage in sharing of ethical questions and the manner of their resolution through the Health Cluster. At the inter-organizational level, the Health Cluster or other appropriate coordination body should establish mechanisms to share information, learnings, knowledge, conduct joint training, and facilitate discussion of ethics concerns across organizations.

5. PROVIDE SUPPORT FOR MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT NEEDS OF STAFF AND OTHERS SUPPORTED BY THE ORGANIZATION WHO MUST MAKE ETHICALLY CHALLENGING DECISIONS

Humanitarian health organizations have a duty of care to their staff and remote managers, which includes protecting the psychological well-being of health workers and managers in the field to help them cope with the sources of extreme danger and stress to which they are subjected as well as moral distress. Organizations should follow best practices internationally as well as accepted norms. These includes personnel practices that provide respite from the stresses of the work and mental health and psychosocial services in the field.

These services should address gender-specific needs of female staff such addressing discrimination, sexual harassment and gender-based violence, and the toll of balancing work and home duties and stresses. Safe reporting mechanisms should be developed, as should means for addressing such reports and resolving cases. The programs developed should be culturally appropriate and locally relevant. These will be facilitated by involving field staff in the development of programs, building on available resources, and regularly assessing needs.

Humanitarian health organizations should also offer resources to address the severe moral distress stemming from the inability to provide the quality of care for which health workers have been trained and believe is their professional responsibility. Organizations should provide tools to individuals

to help them identify, manage, and debrief moral distress before, during and after an event. Where possible, they should modify conditions that lead to moral distress. Toward that end, human resources functions should be linked to the decision-making mechanisms for addressing ethical challenges.

WHO Europe, with the support of the Antares Foundation,²² has developed guidelines for the development of policies by humanitarian

organizations to address needs for staff care and well-being. In 2018, the health cluster in Gaziantep provided training for NGOs based on the guidelines.

Finally, as part of their support for individuals working in dangerous circumstances in the field, as part of their duty of care, support organizations should develop policies regarding compensation for families in the event of the death or injury of a health worker who is exposed to extreme violence.

²² For the Antares Foundation, see <http://www.ataresfoundation.org>

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